



Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747, Boston, MA 02114

MetLife Dental

MetLife®



GIC Retiree Dental Enrollment and Change Form

PLEASE TYPE OR PRINT CLEARLY

01

Insured's GIC-ID (usually Soc. Sec.#) — —		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth ____/____/____	(For GIC use only) Agency/Division # —
Name: Last		First		M.I.
Address (Number and Street)		This is a new Address: <input type="checkbox"/>		
City	State	Zip Code	Home Phone No. ()	
02	NEW ENROLLMENT <input type="checkbox"/> CHANGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/>			
Effective Date: / /		Type of Coverage: Individual <input type="checkbox"/> Family <input type="checkbox"/>		

PLEASE READ CAREFULLY: Important Coverage and Eligibility Notes

- If you don't sign up for coverage when you are first eligible, you will not be able to enroll until the next annual enrollment period.
- If you have family coverage and switch to an individual plan, your spouse and/or your eligible dependents can never rejoin. If you sign up for individual or family coverage and decide to cancel, you can never rejoin the plan.

SPOUSE/DEPENDENT INFORMATION

CHECK ONE: ☐ NEW MEMBER ☐ ADDITION ☐ DELETION ☐ CORRECTION

List below all family members, including your spouse, who will be covered under your dental plan. Married children are not eligible. Please provide all Social Security Numbers and exact dates of birth for each dependent. Attach separate sheet if additional space is required. Coverage for children ends at age 19; to continue their coverage you must complete and return to the GIC a Dependent Age 19 and Over Application for Coverage.

The Group Insurance Commission reserves the right to require you to provide a copy of a marriage certificate, birth certificate, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. This proof may be requested at any time.

Last Name	First	M.I.	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective date: _____

Deduction and Coverage Authorization: I authorize my pension authority to deduct from my pension check the amount required for the dental coverage I have selected. If I am a survivor on direct bill, I understand that I will be billed quarterly for this coverage. I have read and understood the "Important Coverage and Eligibility Notes" above.

X _____
Signature of Applicant Date

FOR GIC USE ONLY

Entered	Verified	Cross Ref. #	Political Subdivision
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